CAMPFIORANTEMATTHEWS

AIR FRANCE FLIGHT 358 CLASS ACTION

TREATING PHYSICIAN FORM - LOSS OF INCOME CLAIM

Strictly Private and Confidential

1. This form must be completed and signed by the treating physician of the passenger who intends to submit further information with respect his or her claim for compensation for loss of income. The information is being collected solely for the purposes of assessing the passenger's claim for compensation for loss of income as a result of injuries sustained aboard flight 358.

2. Loss of income is payable to the passenger who normally had earned income ***but due to injuries sustained aboard flight 358*** *is/was regularly unable to perform the substantial duties of his or her employment.*

Date of flight 358 crash: August 2, 2005.

GENERAL INFORMATION – TO BE COMPLETED BY TREATING PHYSICIAN	
Print passenger's full name	_____ _____ _____ Last name First Name Middle Name
Print Treating Physician's full name	_____ _____ _____ *Last name* *First Name* *Middle Name*
Treating Physician's contact information	_____ _____ _____ *Street Address* *City* *Postal Code* _____ (_____) _____ *Province* *Telephone*
Treating Physician's specialty or area of practice	_____
How long have you known the passenger?	_____ *years* _____ *months*
How long have you been treating the passenger?	_____ *years* _____ *months*
When was the last date that you treated the passenger?	_____/_____/_____ DD / MM / YYYY

DISABILITY INFORMATION – TO BE COMPLETED BY TREATING PHYSICIAN

Describe the passenger's disability which made/makes him or her regularly unable to perform the substantial duties of his or her employment.

_____

_____

Indicate the date when the passenger first became disabled as described above.

_____/_____/_____

DD / MM / YYYY

Is this disability temporary or permanent? (circle one)

Permanent

Temporary

Indicate the symptoms which have caused the impairment resulting in the disability.

_____

_____

_____

If the disability was/is temporary, when did/will the passenger cease to be disabled?

_____

Is this disability directly related to the events of flight 358? (circle one) YES NO

Comments: _____

_____

Did this disability exist prior to the forced landing of flight 358? (circle one) YES NO

Comments: _____

_____

The passenger was/is _____percent disabled as result of injuries sustained aboard flight 358.

I certify that the patient/passenger information provided is true and correct to the best of my knowledge, information and belief.

_____ _____

Treating Physician's Signature *Date Signed*